Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TX 77504

Carrier's Austin Representative Box
15

MFDR Date Received
May 30, 2006

Respondent Name
JACOBS ENGINEERING GROUP INC

MFDR Tracking Number
M4-06-6271-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated June 12, 2006: **"**Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above $40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the $40,000 stop-loss threshold is reached.**"**

Requestor's Supplemental Position Summary Dated October 31, 2001: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeal's Final Judgment…"

Amount in Dispute: $65,827.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated June 23, 2006: "Enclosed please find the original and one copy of **Jacobs Engineering Group, Inc. (Self-Insured's) Designation of Attorney and response to Medical Dispute Resolution** Request for the above referenced matter."

Response Submitted by: Law Offices of John D. Pringle, 807 Brazos, Suite 200, Austin, TX 78701

Respondent's Position Summary Dated July 10, 2006: "Requestor failed to provide any evidence that the disputed dates of service should have been resolved according to the stop-loss exception."

Response Submitted by: Esis Inc., P.O. Box 759, Houston, TX 77001

Respondent's Supplemental Position Summary Dated September 9, 2011: "The referenced file has been assigned to us for submission of a Supplementing Position Statement. To accomplish this we have submitted a

Form DWC-153, requesting the MFDR File. We can file a position statement shortly after receipt of the file requested. Please allow an extension-20 days so that we may address the issues in this apparent claim for stop-loss reimbursement.

Response Submitted by: Downs & Stanford, P.C.

Respondent's Supplemental Position Summary Dated November 17, 2011: "To be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services."

Response Submitted by: Downs & Stanford, P.C., 115 Wild Basin Road, Suite 207, Austin, TX 78746

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
October 8, 2005 through October 10, 2005	Inpatient Hospital Services	$65,827.03	$442.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §124.2, effective August 29, 1999, requires the insurance carrier to notify the Commission and the claimant of a dispute of extent of injury.
4. 28 Texas Administrative Code §124.3, effective March 13, 2000, requires the insurance carrier to file a notice of dispute of extent of injury.
5. 28 Texas Administrative Code §134.600, 29 *Texas Register* 2360, effective March 14, 2004, requires preauthorization for specific treatments and services.
6. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
7. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 97 – Payment in included in the allowance for another service/procedure.
- 42 – Charges exceed our State Fee Schedule adjustment.
- 18 – Duplicate claim/service.
- 50 – These are non-covered services because this is not deemed a "medical necessity" by the payer.
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- W12- Extent of Injury, not finally adjudicated
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment
- W4- No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?

5. Does an extent of injury issue exist?
6. Does a medical necessity issue exist?
7. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The documentation filed by the requestor and respondent to date is considered. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The requestor in its position statement asserts that "The Carrier has not made a legal denial of reimbursement under the applicable rules and statutes…Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges upon reconsideration." 28 Texas Administrative Code §133.304(c), 17 Texas Register 1105, effective February 20, 1992, applicable to dates of service in dispute, states, in pertinent part, that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." Review of the submitted documentation finds that the explanation of benefits were issued using the division-approved form TWCC 62 and noted payment exception codes "97, 42, 18, 50, 150, W12, B13, and W4".

   These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has substantially met the requirements of 28 Texas Administrative Code §133.304(c).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $102,264.04. The Division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement asserts that "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules. However, if the total audited charges for the entire admission are above $40,000, the Carrier shall reimburse using the Stop-Loss Methodology in accordance with the plain language of the rule contained in § 134.401(c)(6)(A)(iii). This rule does not require a hospital to prove that services provided during the admission were unusually extensive or unusually costly to trigger the application

of the Stop Loss Methodology. It is presumed that the services provided were unusually extensive or unusually costly when the $40,000 stop-loss threshold is reached." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

> "The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least two reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

> "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries; and third, it was necessary to purchase expensive implants for use in the surgery."

The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide

documentation to support a reasonable comparison between the resources required for the comparison surgeries. Therefore, the requestor fails to demonstrate that the hospital's resources used in this particular admission are unusually costly when compared to the hospital's resources used in other types of surgeries.

5. According to the January 6, 2006 explanation of benefits, the respondent denied reimbursement for code 99199-Unlisted special service for $1,742.00 based upon reason code "W12".

   28 Texas Administrative Code §124.2(h) states "Notification to the Commission and the claimant of a dispute of disability, extent of injury, or eligibility of a claimant to receive death benefits shall be made as otherwise prescribed by this title and requires the carrier to use plain language notices with language and content prescribed by the Commission."

   28 Texas Administrative Code §133.304(j) states "An insurance carrier shall have filed, or shall file concurrently file, the applicable notice required by §409.021 of the Texas Labor Code, §124.2 of this title, and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denied payment for treatment(s) and/or service(s) based solely on the carrier's belief that: (1) the injury is not compensable; (2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or (3) the condition for which the treatment(s) and/or service(s) was provided was not related to the compensable injury."

   28 Texas Administrative Code §124.3(c) states "Texas Labor Code, §409.021 and subsection (a) of this section do not apply to disputes of extent of injury. If a carrier receives a medical bill that involves treatment(s) or service(s) that the carrier believes is not related to the compensable injury, the carrier shall file a notice of dispute of extent of injury (notice of dispute). The notice of dispute shall be filed in accordance with §124.2 of this title and be filed not later than the earlier of: (1) the date the carrier denied the medical bill; or (2) the due date for the carrier to pay or deny the medical bill as provided in Chapter 133 of this title."

   A review of Division records finds that the insurance carrier did not file a notice disputing the extent of injury for the disputed services billed under code 99199-Unlisted special service for $1,742.00; therefore, the extent of injury issue is not supported.

6. According to the January 6, 2006 explanation of benefits, the respondent denied reimbursement of "patient convenience items" based upon reason code "50". 28 Texas Administrative Code §134.401(c)(6)(A)(v) states, "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are personal items (e.g., telephone, television)." Therefore, the respondent's denial of patient convenience items is supported.

   In addition to patient convenience items, the respondent also denied reimbursement for code 99199-Unlisted special service for $1,494.30 and $16,254.20 based upon reason code "50".

   28 Texas Administrative Code §134.600(h)(3) states "Non-emergency health care requiring preauthorization includes: (3) spinal surgery, as provided by Texas Labor Code §408.026."

   On November 17, 2005, the respondent's representative, Intracorp, gave preauthorization approval for "Admit for 2 days for C5-6 Anterior Cervical Discectomy Fusion with Graft and Instrumentation."

   Therefore, the spinal surgery and related services were preauthorized and the medical necessity issue is not supported for the unlisted special services billed at $1,494.30 and $16,254.20.

7. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

   - Review of the submitted documentation finds that the services provided were intensive care unit (ICU) and surgical; therefore the standard per diem amount of $1,560.00 and $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was two days. The ICU per diem rate of $1,560.00 multiplied by the length of stay of one day added to the surgical per diem rate of $1,118 multiplied by the length of stay of one day results in an allowable amount of $2,678.00.
   - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
   - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at

$31,400.00.

- The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
ACIF Cage	1	$2,800.00	$3,080.00
Plate	1	$3,250.00	$3,575.00
Screw CCM	4	$450.00/each	$1,980.00
TOTAL	6		$8,635.00

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $302.85/unit for Thrombin 5,000 unit, $425.00/unit for Morphine PCA, and $302.30 for Nasacort QA 55MCG/AC. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $11,313.00. The respondent issued payment in the amount of $10,871.00. Based upon the documentation submitted additional reimbursement in the amount of $442.00 is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $442.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	8/23/2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.